King County
Department of
Community and Human Services

Jackie MacLean, Director

401 5th Avenue, Suite 500
Seattle, WA 98104

(206) 263-9100 Fax (206) 296-5260
TTY Relay 711

FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 2.1(a-2)
Selected Service Improvements to Chronically Homeless People (Seattle)

1. Goals (Overarching Investment Strategies)

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of ending homelessness through outreach, prevention, permanent supportive housing and employment (pages 18-21 of the SIP).

2. Objective (Specific Investment Strategy)

#2.1: Partner in initiatives to identify, engage and house long-term homeless people who make the highest use of public safety and emergency medical systems (page 19 of the SIP).

This procurement plan is the third in a series of three that address this objective. The first, a procurement plan to enhance outreach and engagement of homeless people in South King County was approved in 2007 (SIP 2.1(b)). The second procurement plan, approved in March 2008, calls for development of a county-wide database that will identify high utilizers of public safety and emergency medical systems. The database will ultimately facilitate coordinated entry into existing and new housing, services and supports, and is a tool that will be used by the staff and programs to implement the strategies described in this procurement plan.

This third plan describes a set of proposed investments that will improve coordination of homeless outreach, engagement, and entry into treatment and housing for a subset of homeless single adults in Seattle, as described on page 19 of the Service Improvement Plan. In this Procurement Plan, we first describe a group of current services that target homeless people with substance abuse problems – the *King County Emergency Service Patrol or ESP*, which picks up intoxicated people off the streets; the *Dutch Shisler Sobering Support Center*, which provides a safe place to sleep off the effects of intoxication; *REACH Case Management*, an intensive case management service provided to the most frequent users of the Sobering service; and the *High Utilizer Group or HUG*, that meets to conduct individual case planning for the most challenging clients (Historically, this group of services has been known as the "service array for chronic public inebriates"). Included in this Plan is a description of a process that took place to examine what changes were needed and desired in the above services, and lays out a set of planned changes and the rationale behind them. Finally, the Plan details a budget that shows how the requested Levy funds will be used and

how *existing* funds will be reprogrammed to complement the Levy fund investment. The majority will be put out for competitive bid to community-based agencies.

While this redesign is somewhat complex, the Levy's SIP called for strategies to "challenge existing fragmentation," to "fill existing gaps in services and continuums of care" and to "build on existing successful programs or structures." This redesign meets all of these criteria.

3. Population focus

The population focus for this procurement plan is homeless individuals in Seattle who experience primary substance abuse disorders, and who may or may not have co-occurring mental disorders (In the past few years, interventions for those with serious mental illness have been expanded through other resources and are now being implemented). Many of these individuals currently:

- Make frequent use of programs such as the Sobering Center or Needle Exchange
- Spend time on the streets, in libraries, in parks, and in day programs
- Make frequent use of emergency department services in hospitals
- May be cycling through the justice system and at various time are engaged in court-related programs (voluntary or mandatory)

Within this subset of homeless people, veterans will be a population of focus. Currently, veterans account for 21% of the clients on the caseload of the intensive case management program (REACH) for high utilizers of the Sobering Center. In 2006, Health Care for the Homeless program provided services to 446 veterans, of whom 423 were single adults. The majority were engaged in downtown Seattle shelter and medical program sites.

4. Need or Risk Information

- In 2007, the King County Emergency Service Patrol made 13,316 pick-ups of individuals in need of sobering services. The van service makes an average of 1,109 pick ups per month, 85% of which are transported to the Sobering Center. Currently, only 1% of clients admitted to the sobering center are referred to the detoxification center for treatment services.

- In a three month period from October 2007 – January 2008, the Metropolitan Improvement District Ambassadors reported the following in the downtown Seattle area:
    - 355 instances of drug activity observed
    - 414 instances of alcohol activity observed
    - 1,024 referrals made to human services
    - 1,325 instances of panhandling observed

- Harborview Medical Center reviewed the 300 people who had the most frequent use of its emergency department in 2005 and who were served as outpatients (that is, they were not admitted to inpatient care), and found that 40% were homeless.[1]

- In a one-month study of homeless people in the King County jail, it was found that 50% (798 of 1,584) of the inmates seen by Jail Health Services were homeless. The top three diagnoses of the homeless patients were:
    - Cellulitis/abscess[2]
    - Depressive disorder
    - Alcohol withdrawal

- The numbers of deaths of homeless people coming under the King County Medical Examiner's jurisdiction has risen from 82 in 2004, to 94 in 2005, to 110 in 2006. Across the three years, 286 people died and of those 79 (28 percent) died due to acute intoxication. Accidental acute intoxication may be due to alcohol, street drugs, prescription drugs, or a combination.
    - The number of deaths associated with street and prescription drugs remains consistently higher compared to alcohol, across all three years. For example, in 2006, of the 29 acute intoxication deaths, 20 deaths involved any street drugs, 20 involved any prescription drugs, and 7 involved any alcohol.
    - In 2006, cocaine comprised the highest proportion (involved in 18 or 62 percent) of the acute intoxication deaths. Heroin and other opiates were involved in 15 intoxication deaths (52 percent)

- During a six-week period in 2007, four hospitals in Seattle tracked homeless people in need of care following discharge. They identified 333 homeless people. Sixty-nine percent (69 percent) had a substance abuse condition, mental health condition, or both. For that subset where the type of substance(s) was noted, the majority used multiple substances. Various combinations of alcohol, cocaine/crack, and opiates were the most commonly mentioned. This was identified through a mix of self-report and screening tests.

- The 2008 One Night Count of homeless people in King County found that, across all areas counted in King County, there was a moderate (15 percent) increase in the number of unsheltered homeless people in King County, rising from 2,159 in 2007 to 2,482 in 2008 (comparing only the same areas counted). Within the City of Seattle, the rise in same-area comparison from 2007 to 2008 was even greater – 18 percent. The full report is available at the Seattle-King County Coalition on Homelessness website: www.homelessinfo.org/onc.html

- Almost a third of the people served by King County's Health Care for the Homeless Network (HCHN) in 2006 had mental health and/or substance abuse problems. Nearly half had no health insurance.

[1] King County Veterans and Human Services Levy Service Improvement Plan, September 2006, King County Department of Community and Human Services.
[2] There is high prevalence of abscesses and cellulitis among injection drug users.

5. Total Dollars Available

For the specific investment Strategy #2.1, "Partnering in initiatives to identify, engage and house long-term homeless people," the following funds are available.

	2007	Annually 2008-2011
Veteran's Levy	$141,000	$246,000
Human Services Levy	$329,000	$574,000
Total	**$470,000**	**$820,000**

These funds are to be divided between the three procurement plans submitted under #2.1, the South King County initiative, the plan to develop and manage a database of high utilizers, and finally this proposal of outreach and engagement.

- The South King County procurement plan has received $144,000 of the total funds available for 2007 and projects utilization of $370,000 per year in 2008-2011.
- The second procurement plan requested $238,000 of the remaining 2007 funds and projects the need for maintenance level funding of $120,000 per year in 2009-2011.

The remaining unprogrammed funds available for this third strategy, 2.1(a-2) for the period 2008 – 2011 are $1,528,000.

Unallocated 2007 Funds	$88,000
2008 Funds Available	$450,000
2009 Funds Available	$330,000
2010 Funds Available	$330,000
2011 Funds Available	$330,000
Total	**$1,528,000**

Of this amount:

Human Services Levy (70%)	$1,069,600
Veterans Levy (30%)	$458,400
Total	**$1,528,000**

Veteran and Human Services Funding budget detail 2008-2011

Service Component	Oversight	Amount of Levy Funds (70% Human Services Levy / 30% Veterans Levy)
2.0 Full-time employees (FTE) additional Outreach staff	Public Health-Health Care for the Homeless Network (HCHN)	$130,000 per year (2009-2011)
Case Management (Space Lease & Service Expansion)	Public Health-HCHN	$17,000 - 2008 $157,000 per year (2009-2011)
Emergency Service Patrol expansion to 24/7	DCHS-MHCADSD	$75,000 (2008) $130,000 per year (2009-2011)
Integrated Compatible data system	DCHS-MHCADSD	$15,000 - 2008 $15,000 per year (2009-2011)
Start up and transition activities	DCHS-MHCADSD / Public Health HCHN (Budget and roles to be determined, depending on nature of transition activities)	$125,000 - 2008
Total for 2008		**$232,000**
Total for 2009-2011		$432,000 @ 3 years = **$1,296,000**
Total 2008 – 2011		**$1,528,000**

6. Geographic Coverage

The service expansions in this Procurement Plan target homeless adults in Seattle, with a focus on those neighborhoods in and surrounding downtown Seattle where high concentrations of homeless people with substance abuse and/or co-occurring problems are located.

7. Evidence-Based or Best Practice Information

One summary of evidence-based and best practice interventions was developed in March 2007 for the National Symposium on Homelessness Research entitled "*People Who Experience Long-Term Homelessness: Characteristics and Interventions*" (by Carol L. M. Caton, PhD, Columbia University, New York, NY; Carol Wilkins, MPP, Corporation for Supportive Housing, Oakland, CA; and Jacquelyn Anderson, MPP, Corporation for Supportive Housing, Oakland, CA).

The report identified the group of housing and service interventions that are most promising for addressing chronic homelessness. They include the following components:

- Outreach
- Case management
- Discharge planning
- Permanent Supportive housing

Other strategies within the Veteran's and Human Services Levy interventions in homelessness have addressed discharge planning and permanent supportive housing.

This Procurement Plan is focused on outreach and case management. Outreach is "often a first step in the process of engagement . . .repeated brief contacts to establish a relationship often precede an agreement to accept services. Strategies of initial engagement include the offering of food and other concrete services, medical care, and housing." Outreach is most effective when directly linked to a housing placement.

The report also notes that over time, the ACT model (Assertive Community Treatment) has been adapted to better meet the needs of homeless people who have co-occurring mental illness and substance use disorders, and it cites integrated treatment approaches as a best practice for chronically homeless populations. "Integrated treatment is characterized by treatment of the mental illness and the problem with substance abuse by the same clinician or clinical treatment team. This approach eliminates the need for the client to seek treatment for each disorder from different clinicians in separate systems of care." It also cites the importance of motivational interviewing: "Despite the individual barriers that homeless clients have, however, motivation may also play a key role in success in substance abuse treatment. Interventions to enhance motivation and readiness to change and seek treatment are likely to be helpful" (Gonzalez & Rosenheck, 2002).

Additional support for coordinated treatment approaches is cited in "Interventions to Improve the Health of the Homeless: A Systemic Review" (Hwang, Stephen et al., *American Journal of Preventive Medicine,* 2002:29(4)).

> "The data reviewed here indicate that interventions providing coordinated treatment and support for homeless adults with mental illness and/or substance abuse usually result in greater improvement in health-related outcomes than does usual care."
>
> "For homeless people with substance abuse problems, case management resulted in greater decreases in substance use than did usual care."

Finally, several innovative approaches to addressing street homelessness were examined and discussed in the SIP, including Philadelphia's approach to coordinate street outreach, and the San Diego Serial Inebriate program. Such programs use different methods to target homeless people who are the most vulnerable, providing outreach and linkage to case management and housing.

8. Program Description

This section includes the following information:

(a) Background on the planning process
(b) Overview of current services
(c) Results and themes from key informant interviews
(d) Description of planned improvements (including one-page graphic depiction of the envisioned system redesign)

(A) Background on the planning process. Since August 2007, stakeholders involved in providing services to the target population have been involved in a process to redesign and strengthen the way that selected services are currently provided to the Seattle chronically homeless population with substance abuse disorders. This process has been led by the King County Department of Community & Human Services (DCHS), Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and Public Health – Seattle & King County, Health Care for the Homeless Network (HCHN), who currently have responsibility for overseeing significant program resources for substance abusing homeless in downtown Seattle, including the Emergency Service Patrol van, the Dutch Shisler Sobering Support Center, and intensive case management services (REACH). King County staff worked with an "oversight group" (members listed in section 10) to assure coordination and support for this redesign with other current and potential funders, and significant service partners.

The primary goal of the planning process was to improve client outcomes by bringing the service continuum for homeless people with substance abuse conditions into stronger alignment with evidence-based practices, the Ten Year Plan to End Homelessness in King County and the United Way Blueprint to End Chronic Homelessness. It should be noted that the existing programs providing services have assisted hundreds of people who have reduced or eliminated alcohol use, improved their health, and secured stable housing. People sleeping off the effects of alcohol have done so in a safe and low-cost setting. Such outcomes have been the result of committed, trained staff of many organizations.. However, opportunities exist at this time to address specific challenges and gaps, and to coordinate with the United Way initiative to end chronic homelessness. Some changes will be implemented through changes to programs operated by King County, and some changes will be implemented through a competitive request for proposal process.

A Request for Proposal (RFP) for Sobering and REACH services will be released in late May 2008. Contracts with the current community-based service providers are in place through the end of 2008, and any changes will go into effect January 2009. This Procurement Plan will invest Levy funds in selected components of the service improvement, and add those funds into the upcoming RFP. The RFP will therefore include both existing

funds and Levy funds and together the resources would be used to carry out the envisioned change. See section 11 for details on the timeline.

(B) Overview of current services. The following are highlights of the emergency service patrol, sobering support center, case management, and high utilizer coordination services targeting homeless substance abusing population. Please see Appendix A for more background on these programs and who they serve.

Emergency Service Patrol (ESP)
ESP operated by King County Department of Community & Human Services, MHCADSD.

- In 2007, the ESP van made 13,316 pick-ups of individuals in need of sobering services
- The van makes an average of 1,109 pick-ups per month
- 85 percent of pick-ups are transported to the sobering center
- The van does not operate from 8:00 a.m – Noon each day, during which time there is unmet need for transportation and engagement
- There are hours when pick-up activity is lower, allowing for expanded outreach and transportation activities
- In 2007, 960 individuals were picked up due to pro-active outreach on the part of ESP personnel. This accounted for 7 percent of the individuals picked up
- Boundary reduction occurred in past due to budget cuts, leaving areas of Seattle not served

Sobering Support Center (located at 1930 Boren, Seattle)
Services provided by community-based agency under contract with King County Dept. of Community & Human Services, MHCADSD.

- In 2007, the Sobering Support Center served 2,101 unduplicated individuals
- There were 23,047 admissions to the center in 2007 (an average of 63 per day)
- The census at the center is highest between 8:00 p.m. and 7:00 am and lowest between 7:00 a.m. and 4:00 p.m.
- The ESP van accounts for 49.5 percent of the referrals to center and walk-ins account for 47.8 percent of admissions
- Only 1 percent of clients admitted to the center are referred to the detoxification center for treatment services
- The sobering area of the facility is under utilized during the daytime hours (8:00 a.m. to 4:00 p.m.

Intensive Case Management (REACH)
Services provided by community-based agency under contract with Public Health-Seattle & King County, Health Care for the Homeless Network.

- In 2007, the REACH team worked with 190 unduplicated homeless individuals
- The team has 6 case managers: average caseload = 31.6 clients per case manager
- In an average year, the team can accommodate about 36 new clients (that is, about 19 percent of the caseload transitions off of case management in a given year, creating ability to take new clients)

- In the 3-year period 2004-06, 70 percent of the Sobering Center's high utilizers were engaged in REACH services
- In 2006, 21 percent of those on the REACH caseload were veterans
- Overall, the current size and capacity of REACH appears to be adequate for case management of Sobering high utilizers, but is inadequate for further expansion to take referrals from other locations or populations without added resources

Chemical Dependency High Utilizer Group (HUG)

- The HUG meets every other week at Seattle Indian Health Board, and is convened and staffed by the King County MHCADSD chemical dependency high utilizer liaison. Cases presented at HUG are client specific and are for people whom other interventions have not succeeded. Staff from various systems are brought together to discuss the person and develop an intervention plan.

(C) Results of Key Informant Interviews. In order to identify elements that were working well and areas for improvement, MHCADSD and HCHN conducted a series of interviews with stakeholders. Eleven groups of stakeholder interviews were conducted with key informants between the dates of October 26 and November 16, 2007. The following were consulted, including all current community-based organizations that are currently under contract with King County to provide services.

- **Emergency Service Patrol and Involuntary Treatment** – Wendy Pompey, Rose SooHoo, Tammy Jo Honner, Luis Rosado, Caroline Bacon
- **Downtown Seattle Association/Metropolitan Improvement District** – Kate Joncas, Dave Dilman, Ryan Bayne, Peggy Dreisinger, Dave Willard
- **Department of Social & Health Services** – Mark Dalton, Will Ward, Don Hayes
- **Recovery Centers of King County/Sobering Unit** – Pat Knox, Lily Morgan-Hunting, Fred Bryant, Robert Callahan
- **Washington State Department of Social and Health Services (DSHS)/Division of Alcohol & Substance Abuse** – Robert Leonard, Harvey Funai
- **Downtown Emergency Service Center** – Dan Floyd, Graydon Andrus
- **Seattle Indian Health Board** – Al Sweeten, Aren Sparck
- **City of Seattle** – Jerry DeGrieck, Judy Summerfield, Sgt. Paul Gracy, Lorri Cox, Cindy West
- **Harborview Medical Center** – Ed Dwyer O'Connor, Peter Goodman
- **Public Health** – Michael Hanrahan (Needle Exchange); Mark Alstead (Jail Health Services)
- **Evergreen Treatment Services/Pike Market Medical Center/REACH case management** – Ron Jackson, Chloe Gale, Kelley Craig, Jane Kennedy, Jeff Thelen-Clemmons

Themes from the key informant interviews included the following:

- *Leadership: Weak communication about the various programs' mission, goals, outcomes, eligibility, and services.* Nearly everyone interviewed identified gaps in communication

of some kind. Funders commented on a lack of "public relations" and felt that the programs operating out of the Dutch Shisler Sobering Support Center need to improve the ways they communicate their mission as well as their outcomes. More reports are needed to help the community understand the value added of these services. Stronger overall program management would help build relationships, stabilize funding, advocate for system changes, and address historic "territory" challenges and philosophical differences across programs and agencies, moving them toward clearer evidence-based practices and reinforcing those already in place.

- *Interest in broadening the target population to increase interventions with illegal drug users.* Many of the current services are geared toward those whose primary issue is alcohol abuse. Illegal drug users are more spread out, less visible, and less willing to engage in services. However, this group has a significant presence on the streets, in emergency departments, and in jail. Many of those interviewed expressed the need for more engagement work and services to illegal drug users.
- *Broaden outreach: proactively engage clients on the street and coordinate outreach efforts; improve transportation.* Many stakeholders also identified the gap in outreach to substance abusers on the street, and a need for entities like the Metropolitan Improvement District (MID) and the police to have a team to whom they could refer individuals who are posing challenges on the street, regardless of whether they are a sobering high utilizer. Expanding the ESP van to 24/7 and changing its role in outreach and transportation should be part of this strategy. Stakeholders commented that if services are expanded, it needs to be done carefully so as to balance the carrot/stick appropriately.
- *Get more people engaged in treatment and move systems to be better prepared to respond when clients are motivated.* Most people interviewed identified the lack of detox beds and the long wait for a treatment bed as significant barriers. Some saw a need for more interim beds for those who have been assessed and are waiting for treatment. Several specific recommendations were made about how to improve the assessment process and how to expand access to treatment in non-traditional settings, including modifying the use of the existing Sobering Center to provide treatment services during the day.
- *Data systems need to be examined to assure maximum coordination and efficient use of resources.* Currently, ESP, REACH, and Sobering all use different data systems. Stakeholders commented that that is difficult to get information about clients and the current plan for a given client. Also, data is not readily available for planning or outcomes. Groups discussed the advantages of being able to share limited data on shared clients if they used the same software. Also, Memoranda of Understanding (MOU) or business associate agreements among agencies to facilitate the sharing of data would be helpful.
- *Incorporation of DSHS and medical staff is working well.* Those interviewed spoke highly of the on-site DSHS services at Sobering and the integration of nursing service into REACH/Sobering (via Pike Market Medical Clinic). More out stationed DSHS staff are desired at Sobering and other locations. Additional advocacy may be needed in this area to demonstrate the need for and value of the outstationed staff.

- *High Utilizer Group (HUG) is particularly valuable and working well.* Nearly every person interviewed who had knowledge of the HUG indicated that it was valuable and working well. This group, convened by the chemical dependency (CD) high utilizer liaison, does case staffing and develops a plan for the most challenging individuals, those for whom previous interventions at Sobering, 1811, REACH, Detox, hospitals, and involuntary treatment have not been successful. Those involved in a particular case come to the group and develop a plan of action, which has a better chance of being successful because all the players are there and know the plan. Some saw need to expand to working with IV drug users as well, while recognizing that they are generally less motivated, more difficult to engage. Some would like to see the HUG spend more time on new clients.
- *Housing.* Not surprisingly, all groups expressed the need for more housing, both wet and dry. Most stakeholders held positive view of the Downtown Emergency Service Center's 1811 Eastlake residence and its apparent impacts on the streets, sobering, and other systems. Some expressed a desire to partner with 1811 in a more active way. Some people indicated that a type of nursing home is needed for people with significant medical conditions that prohibit them from living in the current housing options (people who need assistance with activities of daily living). There is a need for permanent housing specific to Native Americans – they can often get isolated from their community in the current programs.

(D) Planned Improvements. Based on the results of the interviews, data analysis, and consultation with various stakeholders, King County staff will oversee implementation of the following recommended changes.

General recommendations applicable to all service components:

- **Strengthen leadership, accountability, and evaluation.** We will develop effective oversight, monitoring, reporting and evaluation components to improve accountability of the proposed changes described below. We will share the collective results of the interventions with funders, stakeholders, taxpayers, business community, service providers, and clients. King County DCHS-MHCADSD has a Program Manager III position (reports to Jim Vollendroff) that will play a key role in unifying the interventions and services that will fall under the umbrella of the redesigned "Dutch Shisler Sobering Support Center."
- **Broaden the target population.** We will broaden the target population for ESP, sobering support, and case management services to include homeless people abusing illegal drugs as well as those whose primary substance use is alcohol. Assure that services can address the needs of those with co-occurring disorders.
- **Incorporate the use of a compatible/shared data system, and participate in Safe Harbors.** The Sobering Center, Case Management Services, ESP, and the new street outreach team will all be required to use a common data system will be in place to track services provided and outcomes, and to allow information sharing among the programs. We anticipate that the selected software will need to be customized to serve as the data system for these programs. Agreements will be in place so that clients are admitted to a system of care at the "Dutch Shisler Sobering Support Center" and not individual

programs so that coordination of services is assured. This differs from the status quo in that, currently, these different programs operate somewhat independently, and now all their clients will be entered into a shared data system so that the status and plan related to a given client can be readily known. Regardless of what data system is used, required data elements will be submitted to the Safe Harbors Homeless Management Information System.

- **Collaborate with housing development funders and providers to assure appropriate permanent supportive housing is accessible to the target population.** Over the past several years, those who fund and provide housing for homeless people have prioritized certain units for homeless people who are the most vulnerable and make frequent use of various expensive public systems. Capital, operating, and supportive service funding for the housing units is being made available from various federal, state, local, and private resources – including the Veterans and Human Services Levy. New funding from the mental health/substance abuse sales tax increase may also provide an opportunity to help increase the supply of housing dedicated to those with substance abuse conditions, among others.

  Permanent supportive housing is the model of housing appropriate for chronically homeless people with substance abuse/chemical dependency. King County MHCADSD and Public Health will continue their active participation on the Homeless Housing Funders Group to advocate for specific units to be dedicated to this target population. Some planned housing projects in the development "pipeline" and scheduled to open from 2009 – 2011 may be appropriate sites at which to negotiate units for these high utilizers and assure that the housing sites have the types and levels of on-site services that they would need to adequately support the residents. In addition, some individuals are expected to be housed through other resources such as Shelter Plus Care subsidies, transitional housing programs, or clean and sober housing placements available through substance abuse treatment agencies. A combination of these housing resources is needed both to provide as much supply as possible, and to allow choice for a given individual. Some people may prefer housing which does not require abstinence, for example, while others will want or need a clean and sober environment. Because housing placement is one of the outcomes of the sobering service and case management programs, King County and the contract partners selected through the upcoming RFP process will be closely involved in developing and maintaining these housing partnerships.

The following sections provide more detail on the specific recommendations for each of the major service components falling under the Dutch Shisler Sobering Support Center. Some of the activities described, such as the Client Coordination Team, have a broader purview but are closely linked to each other.

Service Area One: Outreach, Engagement, and Transportation

Coordinate Outreach, Engagement, and Housing Linkage. King County MHCADSD and Health Care for the Homeless will participate in the implementation model proposed by United Way of King County as part of its "Blueprint to End Chronic Homelessness." King

County's role would be—in cooperation with the City of Seattle and United Way—to provide the staff support to the envisioned "Client Coordination Team" through which many of the "visible street homeless" and "high system users" will be identified, engaged, and eventually housed. Staffing would be accomplished jointly by (1) a new position to be created in Health Care for Homeless Network focused on coordination functions (contingent upon funding being secured) and (2) an existing position in King County MHCADSD among whose functions include oversight of the High Utilizer Group.

The Client Coordination Team, which will meet weekly or bi-weekly, will bring together the various outreach/engagement programs that have the most contact with homeless people who are visible on the streets and/or high system utilizers. Engagement programs with funding from King County and/or City of Seattle would be required to send a representative and others will be asked to join voluntarily (e.g, the Downtown Seattle Association's Metropolitan Improvement District program). This team will coordinate the delivery of services to these target populations in order to knit together existing and new outreach efforts. This team will assure that outreach activities are not duplicative, provide a vehicle for mobilizing and prioritizing outreach. Given that many neighborhoods have unsheltered homeless people in need of outreach and may request assistance, this team will also be the place where requests for outreach services will be discussed and prioritized. Outreach resources will be limited and unable to maintain a regular presence in all needed areas of the City, but the team will have flexibility and may be able to help a given area with specific problem-solving on a case-by-case basis.

The team will collaborate with MHCADSD to gather needed data on and tracking of high utilizers, and work with Homeless Housing Funders Group and the United Way initiative's implementation group to coordinate access to and placement into selected allocations of housing set asides as they come on-line. This Client Coordination Team will refer specific individuals to the High Utilizer Group for cross-system case planning as required but will not act as a client case staffing body.

Use of the High Utilizer Database. One of the tools that the Client Coordination Team will use is the High Utilizer Database, whose development is being supported by the Veterans & Human Services Levy per Procurement Plan 2.1 (a-1). As described in that plan, the database will be used to promote rapid, targeted outreach and engagement. Here is an example of how the database could be used by the Client Coordination Team:

- Assume that a new housing site is opening that will have 10 set-asides for homeless high utilizers, and funders have worked with the housing site to assure it will be staffed to support those with polysubstance abuse problems and chronic medical conditions. The database could produce a list of the top 10 people meeting a profile of high hospital use, high use of the sobering center, and frequent cycling through the jail. The Client Coordination Team would then meet to determine whether any existing programs are engaged with those individuals, and, for those who are not, develop a plan to deploy the appropriate outreach team(s) to locate, engage, and assist them in accessing housing.

The specific functions and procedures of the Client Coordination Team and High Utilizer Group are under continued discussion with United Way of King County, City of Seattle, DCHS-MHCADSD, Health Care for the Homeless, and others. It should be noted that high

utilizers are one focus group of the Client Coordination Team, but would not be the sole focus. They will also be working to address the long-term, vulnerable street homeless population regardless of whether they are making high use of sobering, hospitals, and the justice system.

Establish outreach & engagement service. A Seattle-focused street outreach/engagement service targeting homeless substance abusers will be established through the following:

- Two full time-equivalent outreach/engagement positions to be funded by the Veterans & Human Services Levy
- Other engagement capacity created by modifying role of the ESP staff

Through this combination of new resources and the reprogramming of existing resources, we will assure that the ESP always has outreach as part of its core function. We will also create a flexible outreach response for areas outside the ESP boundaries. This will allow for expansion of services to illegal drug users. Team will provide flexible response to police, MID, ESP, & others to engage with and link homeless people to services.

The goals of outreach and engagement are to build trust and relationships with people on the streets, increasing their motivation to change and supporting them in accessing services and housing. While it is ideal for outreach teams to have direct access to permanent housing placements, and while such set-asides may (and should) at times be part of the resources of outreach teams for the highest utilizers they encounter, teams still can make progress with people on the streets by linking them to existing service array of services including hygiene, day centers, health clinics, benefits, shelters, transitional housing, low-income housing waiting lists, and substance abuse/mental health treatment.

We will create a single mechanism (point person/dispatcher, call-in number) be established for business, MID, Police, etc. to make referrals to the outreach team or if they are otherwise uncertain who to contact. The specific procedures for such a mechanism requires further dialogue with entities involved in outreach.

Modify role of ESP. The role and responsibilities of the ESP van will be modified. The van will return to 24 / 7 service, and staff will provide more proactive outreach and an expanded transportation role in addition to its current functions. It will continue to transport intoxicated persons to sobering. Current job descriptions of ESP personnel will be updated to include proactive outreach. ESP personnel will be mobile, and trained in skilled outreach to intervene with any individual on the streets appearing homeless and or in need of assistance.

Results: Reduction in street homeless; successful engagement of homeless persons into any service (shelter, day center use, case manager, benefits, etc.)

Service Area Two: Case management Services

Strengthen case management services. We will continue and expand the interdisciplinary REACH case management service. In addition we will provide intensive case management

& health services to people with chronic substance abuse problems, taking referrals from the sobering service, hospital emergency departments, and the High Utilizer Group.

Several key improvements in the program will be made including: (1) moving the team's home base out of the sobering facility in order to address the space crunch, although some members of the team will still provide on-site services at sobering center; (2) develop mechanisms to share client information (e.g, through use of compatible/shared case management software); (3) clarify procedures and working agreements (4) expand the definition of the criteria needed for clients to receive case management services and hours of availability (5) clarify criteria under which a client is transitioned off the case management caseload.

A basic principle will be that the program, wherever possible, will actively work toward helping clients establish effective relationships with staff in treatment and housing agencies so that they can transition clients off their caseload over time. This is needed in order to free up capacity to accept new clients. The team may need to continue supporting some clients who have Shelter Plus Care or who have needs not otherwise supported by their housing provider.

Results: Team will successfully target and serve highest utilizers/most vulnerable, and outcomes will include improvements in housing, CD treatment outcomes, linkage to benefits, and linkage to health care.

Service Area Three: Operation of the Dutch Shisler Sobering Support Center

Recast the "sobering center" to a "service center" and strengthen both services and protocols for linkage to treatment. The sobering component will continue to operate 24/7 and continue to provide sleep off services. Services will be expanded to actively serve those addicted to other drugs. Given the 24-hour nature of the service, specific changes will be made to the sobering center's role during daytime hours. Daytime activities will include substance abuse assessment and treatment services, drop in services, and diversion for low level non violent offenders in need of substance abuse services as opposed to incarceration.

- 24/7 facility:
  - 4 p.m. – 7 a.m = primary use is sleep off
  - 7 a.m. – 4 pm. = primary use is drop in for groups, linkage to benefits, health care, substance abuse assessment and treatment services, etc.
  - As possible, establish programming to respond to special needs of women, Native Americans, heroin users, etc.

In addition, individuals who repeatedly use sobering and/or case management services will be enrolled in treatment. The intent is not to bar people from sobering services—the facility needs to continue to serve a sleep-off function to prevent the people and costs from shifting to other systems—but rather assure that each time one visits the center, an approach is made to engage the individual. Treatment activities will include services from a full continuum of substance abuse interventions. These interventions will include harm reduction activities, motivational interviewing, out patient treatment, detoxification and/or residential treatment.

To address individuals who repeatedly and frequently use the facility, specific criteria will be established (e.g., a certain number of admissions) that triggers a referral to the chemical

dependency Involuntary Treatment Services (CDITS) staff co-located at the facility. CDITS personnel will present the case at the High Utilizer Group (HUG)[3] for case staffing and, if appropriate, initiate involuntary treatment.

Results: Increased numbers of people enrolled in treatment and linked to other services.

Service Area #4: Treatment / Involuntary Treatment

King County will continue to provide chemical dependency involuntary treatment services directly. Strengthen referral mechanisms between ESP, case management services and sobering to on site CDITS staff. Criteria will be developed to trigger when referral for investigation of CDITS or referral to HUG is mandatory. All clients who use the sobering service will be screened and, when appropriate, admitted to treatment.

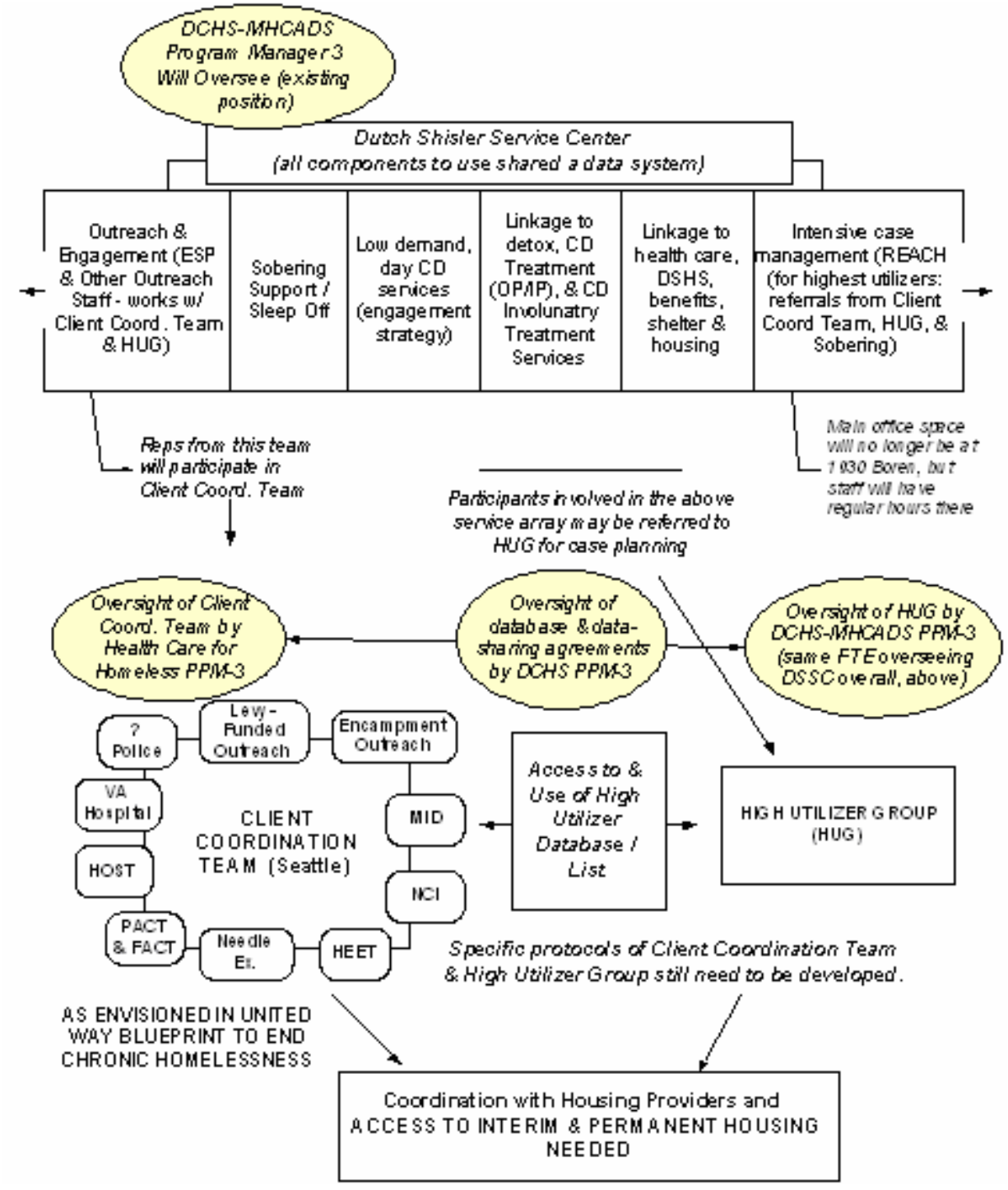
Service Area # 5: Coordination and Evaluation

Staff of MHCADSD/HCHN would assure the following functions are covered:

- Negotiate MOUs among different programs; convene partner agencies
- Prepare logic model and progress reports; seek resources for evaluation
- Oversee and strengthen existing chemical dependency High Utilizer Group (HUG)
- Oversee a street outreach coordination group (referenced above in Service Area #1)
- Assure housing linkages: develop liaison to the housing set-asides being developed through partners in the 10 Year Plan to End Homelessness
- Seek resources for evaluation and coordinate with evaluators

[3] The HUG meets every other week at Seattle Indian Health Board, and is convened and staffed by the King County MHCADSD chemical dependency high utilizer liaison. Cases presented at HUG are people for whom other interventions have not succeeded, and staff from various systems are brought together to discuss the person and develop a plan.

Proposed Vision for Dutch Shisler Sobering Support Center and its Connection to Proposed System-Level Coordination of Outreach & High Utilizers



Proposed role of current funds and Levy funds in implementing the proposed changes:
The table below lays out the five key service areas discussed in the previous section, noting current resources, additional resources needed/proposed, and how the service would be provided. Levy funds are proposed for (1) outreach & engagement, (2) emergency service patrol hours expansion, (3) case management, (4) data system and (5) evaluation support.

Area	Current Funding Resources	Proposed Use of Levy Funds – 2008	Proposed Use of Levy Funds per year 2009 - 2011	Other New Funds	Service by community provider (and thus selected by RFP) or direct by King County?
Service Area 1: Street outreach & engagement	None	None	Propose Vets & HS Levy funds to establish a 2-person outreach/ engagement team $**130,000**/yr additional	None	Community Provider (subject to RFP)
Service Area 1: ESP Modified Role	Current total cost approx. $1.4 million/year *Federal*: $368,335 *State: $*4,000 *County:$* 698,866 *City of Seattle*: $328,799	Propose Vets & HS Levy funds to enable ESP van to return to 24 / 7 operation **$75,000**	Propose Vets & HS Levy funds to enable ESP van to return to 24 / 7 operation $**130,000**/yr additional	None	Provided directly by King County staff (not subject to RFP)
Service Area 2: Modify/strengthen intensive case management services	Existing annualized support is approx. $435,086 (includes Medicaid Match funds, City of Seattle, & federal HCHN) Note: This includes funds currently contracted to Evergreen Treatment Services & Seattle Indian Health Board. Funds that support the RN position will not be subject to this RFP).	6 months of lease costs 2008 **$17,000**	Propose Levy funds to support the lease costs for case management team and to expand multidisciplinary case management capacity and hours. **$157,000/yr additional**	None	Community Provider (subject to RFP)

Area	Current Funding Resources	Proposed Use of Levy Funds – 2008	Proposed Use of Levy Funds per year 2009 - 2011	Other New Funds	To be provided by CBO (and thus selected by RFP) or direct by King County?
Service Area 3: Sobering & day service operations at the Dutch Shisler Sobering Support Center	Existing budget $439,474	None	None	Add $75,000/yr in Chemical Dependency treatment funding from State CD contract	Community Provider (subject to RFP)
Service Area 4	Chemical Dependency Involuntary Treatment services (provided by King County DCHS) – 2.0 FTEs Existing budget $ 194,000	None	None	N/A	Provided directly by King County staff (not subject to RFP)
Service Area 5: Coordination: (a) Coordination of Client Coordination Team (including street outreach coord) (b) High Utilizer Coordination (including High Utilizer Group)	(a) Funding to be determined (b) City of Seattle (for CD high utilizer liaison position & HUG staffing)	None None	None None	To be determined. None	Provided directly by King County staff (not subject to RFP) Provided directly by King County staff (not subject to RFP)

Area	Current Funding Resources	Proposed Use of Levy Funds – 2008	Proposed Use of Levy Funds per year 2009 - 2011	Other New Funds	To be provided by CBO (and thus selected by RFP) or direct by King County?
All Areas. New data system for ESP, REACH, Sobering	None	**$15,000** to begin software customization	Propose Levy funds to support the implementation of compatible/shared data base including customization. **$15,000/yr**	None	To be determined
All Areas. Transition support and/or training as needed (recognizing that if different contract partners are selected, funding to transition between contractors without disrupting client service would be needed.)	None	**$125,000 –** for transitional staffing if needed, recruitment costs, start up equipment, and other one-time start up.	None	None	N/A
TOTAL		**$232,000** **For 2008**	**$432,000 per year** **For 2009 – 2011**		

9. Disproportionality Reduction Strategy

Racial inequities are clearly demonstrated within the chronically homeless population. According to the 2007 One Night Count report, 60 percent of the individuals for whom they had race information indicated that they were people of color (People of color comprise 27% of the general population in King County).

The interventions described in this Plan specifically target the homeless substance abusing population and are geared to move them toward treatment and permanent supportive housing. Disproportionality would be reduced by targeting this population and linking them to services and housing. Based on the demographic profile of the population, specific interventions appropriate for Native Americans and Hispanic populations will be critical.

10. Coordination/Partnerships

This proposed redesign of the service system for homeless substance abusing population in Seattle was developed in conjunction with many stakeholders. Specific efforts were made to coordinate with the Committee to End Homelessness and the United Way initiative to end chronic homelessness by convening and working with an oversight committee who provided their perspective and advice throughout the process.

Members of the Oversight Committee include:

Bill Block, Committee to End Homelessness in King County
Lorri Cox, City of Seattle Community Court
Mark Dalton, DSHS Belltown Community Services Office
Jerry DeGrieck, City of Seattle Human Services Department
Ed Dwyer-O'Connor, Harborview Medical Center
Mike Elsner, King County MHCADSD
Trudi Fajans, Public Health – Health Care for the Homeless Network
Vince Matulionis, United Way of King County
Bill Rumpf, City of Seattle Office of Housing
Kate Speltz, King County Housing & Community Development
Barbara Vannattter, King County MHCADSD
Jim Vollendroff, King County MHCADSD
Cindy West, City of Seattle Human Services Dept.
Janna Wilson, Public Health – Health Care for the Homeless Network

Also see the list of stakeholders interviewed, presented in section 8, Program Design.

11. Coordination with veteran-serving systems and expanded veterans services

Coordination between community based services offered through the Dutch Shisler Sobering Support Center and veteran program including Veterans Hospital and other County Veteran Programs will be increased. Veterans and/or family members in need of services offered through existing programs will be assisted in access and when appropriate transported to needed services. Current staff in veteran serving programs will be invited to join the newly formed Client Care Coordination Team.

12. Timeline

July 9, 2007 – July 31, 2007	Background research and development work
August 15, 2007	Oversight Committee Meeting
August 27, 2007	Key informant interviews begun/Data collection
September 6, 2007	Oversight Committee Meeting
October 4, 2007	Oversight Committee Meeting
November 2007	Key informant interviews continue
January 11, 2008	Oversight Committee Meeting/overview of recommendations
February – May 2008	Procurement Plan & RFP development
April 16 & 17, 2008	Presentation of Procurement Plan to Levy Oversight Boards
April 18 – May 2, 2008	Public Comment Period
May 21 & 22, 2008	Final Review by Levy Boards
Late May 2008	RFP Released
July/August 2008	Notification of Awards
July – Dec 2008	Contract negotiations and, as needed, transition activities
January 1, 2009	New and redesigned services begin

13. Outcome(s), Including disproportionality reduction outcome(s)

- Increase the percentage of the Dutch Shisler Sobering Support Center clients who access substance abuse treatment
- Linkage to and use of primary medical care
- Linkage to benefits
- For clients receiving intensive case management, establish target for % that improve housing, including separate tracking of those placed in and maintaining permanent housing

System outcomes

- Reduction in street homelessness in the downtown Seattle area
- Reduction in use of sobering, jail, and emergency department use among those receiving intensive case management services once housed

14. Dismantling Systemic/Structural Racism Strategy

King County DCHS-MHCADSD staff have participated in training related to undoing institutional racism with a specific emphasis on the processes employed to procure and contract with community based agencies. The tools and strategies identified in those trainings will be utilized to support current and future practices related to this project.

King County departments, including both Public Health and DCHS, are participating in a new Equity and Social Justice initiative. When the proposed new equity impact assessment and review tool is available, staff will examine how it can be applied to this project and be incorporated into decision-making.

Staff from Health Care for the Homeless are involved in the community dialogue process designed to increase awareness among community members of equity and social determinants of health and to spur action. In March 2008, HCHN staff will itself begin to engage in this dialogue with a screening and discussion of "Unnatural Causes."

15. Cultural Competency

All DCHS staff attended a training to improve cultural competency. In addition, select staff attended additional training relevant to culturally competent contracting and monitoring. DCHS and its divisions and programs are concerned about cultural competency and will be holding intensive sessions with staff regarding cultural competency in RFP processes and contract development this spring. All RFPs will include questions about cultural competency and how the ethnic and cultural make-up of clients is to be addressed in agency planning, evaluation and service provision.

16. Alignment within and across systems

As described in the Program Design section of this Procurement plan, development of the proposed system changes and this procurement plan has involved all the major systems that link to the Emergency Service Patrol, Sobering Center, and case management services.

17. Improvement in Access to Services

By expanding the hours and transportation role of the Emergency Service Patrol, it will be easier for homeless people to get to detoxification, treatment, and related services. Expanding outreach and case management will increase the numbers of people who are linked to services and housing. And by working to broaden the target population to those using illegal substances (not just alcohol), access will be expanded.

18. Provider Selection/Contracting Process

As explained in the "Program Description" section, this Procurement Plan intends to combine Levy funds with other existing local resources in order to implement service improvements.

- Services implemented by King County directly (ESP, CDITS) are not subject to competitive Request for Proposal Process
- Operation of sobering support, day services, and intensive case management services at the Dutch Shisler Sobering Support Center will be provided by one or more community-based agencies, to be selected in response to an upcoming joint RFP to be issued by King County DCHS-MHCADSD and Public Health- Health Care for the Homeless Network
- Representatives from the Levy Oversight Boards will be included on the RFP review panel, along with other people who have expertise in homelessness and substance abuse interventions

19. Process and Outcome Evaluation

The investment strategy to identify, engage and house chronically homeless high utilizers will be evaluated through measurement of processes and outcomes. MHCADSD will coordinate with the DCHS, Community Services Division levy evaluation section to measure the effect of the Levy on processes such as timely and appropriate referrals, collaboration and other system level changes. Typical outcomes of outreach and engagement programs are increased housing stability, enrollment in treatment and primary care, and increased income (including veterans' benefits and state entitlements). These outcomes are in alignment with the overall goals of the Levy.

Specific outcomes to be measured:

Number of clients referred and admitted to Detoxification from Sobering
Number of clients admitted into the treatment system from Sobering and Case Management
Number of clients accessing or linking to primary care for medical services
Number of clients linking to and accessing benefits
Number of clients receiving intensive case management, percent that improve housing, including separate tracking of those placed in and maintaining permanent housing
Reduction in street homelessness in the downtown Seattle area
Reduction in use of sobering, jail, and emergency department use among those receiving intensive case management services once housed
Number of ESP transports and Pickups once returning to 24/7
Number of ESP staff initiated pickups
Number of clients sent to Pioneer Center North for Involuntary treatment.

Attachment A:

Background Information on Existing ESP, Sobering Center, and Case Management

Emergency Service Patrol (ESP)

Location: 1930 Boren Avenue, Seattle

Hours: 12:00 p.m. – 8:00 a.m., seven days per week.
(20 hours per day or 140 hours week)

Number of vans: Two vans operate from 5:00 p.m. – 1:00 a.m.
All other times = 1 van on duty
Two staff persons per van

Shifts:

Day Shift:	12:00 pm. – 10:00 pm.
Swing:	5:00 pm. – 1:00 a.m.
Night:	10:00 p.m. – 8:00 a.m.

Transports: ESP service averages 40 picks up/transports per day.

Distribution of picks up across shifts:

Day:	33.5%
Swing:	33.2%
Night:	33.3%

No pick ups from 8:00 a.m. – 12:00 p.m., van not in service.

Demographics:

Male	90%
Female	10%
White	45%
American Indian/Alaska Native	30%
Hispanic	12%
African American	9%
Other	4%

Destination:

Sobering Center:	85%
1811 Eastlake	6%
Harborview to detox	5%
Detox	2%
Harborview, other hospitals	2%

Catchment Area:

- **North Boundary** begins in the west at 8th and W McGraw St. and follows an easterly direction along Queen Anne Drive to Westlake Avenue N following the shores of Lake Union to Fairview Avenue N until the 1400 block, then the south along I-5 to Lakeview Blvd. and then following Belmont Ave. E, Summit Ave. E, Prospect St., Harvard Ave. E, Highland Drive, and 10th Ave. E completing the North Boundary with the northern boundary of Volunteer Park;
- **East Boundary** follows 15th Avenue to approximately Yesler Way the jogging slightly east to Boren then south on Boren to Dearborn Avenue then east on Dearborn Avenue to Interstate 5 then following along Interstate 5 to Spokane Street;
- **South Boundary** is from Interstate 5 along Spokane Street to East Marginal Way;
- **West Boundary** is along Alaskan Way and the Waterfront to W Mercer Street then continuing north using 5th Avenue W, Roy St., W Olympic Pl. and 8th Avenue W to the intersection of 8th Avenue W and W McGraw St.

Current Staffing:

1 Chemical Dependency Screener Supervisor

1 Chemical Dependency Program Screener Lead

8 FTE Chemical Dependency Program Screeners

1 (.80) Part time Chemical Dependency Program Screener

1 (.60) Part time Chemical Dependency Program Screener

1 Administrative Specialist II

10 True Temporary Chemical Dependency Program Screeners

Sobering Support Center

Location: 1930 Boren Avenue, Seattle

Hours: 24/7

Facility: Sobering Support Center (staffed by Recovery Centers of King County)

Also located at this site:

- Home base for ESP staff/dispatch
- Chemical Dependency Involuntary Treatment (King County MHCADSD staff)
- REACH Case Management Team (Evergreen Treatment Services; 1.0 FTE Nurse from Pike Market Medical; 0.4 FTE Mental Health from Harborview Medical Center (HMC) - Pioneer Square Clinic)
- On-site services/regular hours from Will Ward, DSHS Belltown Community Services Office – Assistance to Native Americans for DSHS services

- Second floor – Community Psychiatric Clinic Safe Haven, Harbor House

Capacity: 60 people at any given time

Admissions: Average number per day in 2007 was 63

- The highest number of clients by census count occurs between 10:00 p.m. and 5:00 a.m., followed by the period of 4:00 p.m. to 10:00 p.m.
- The census drops dramatically from 5:30 a.m. to 7:30 a.m. and by 10:00 a.m. there may be one or two clients in the center. Often there are no or very few clients in the center between 10:00 a.m. and 4:00 p.m.
- Serves about 1,000 people over the course of a year
- Clients stay approximately 8 – 14 hours until they have slept off the effects of alcohol or other drugs

Services:
- Sleep off
- Health status monitoring
- Referral to Detox (2 beds per day at detox are reserved for Sobering Center referrals) & treatment
- Referral to Involuntary Treatment services
- Referral to REACH case management

Demographics:

Male	87%
Female	13%
White	43%
American Indian/Alaska Native (AI/AN)	16%
Hispanic	12%
African American	18%
Other	12%

97% are homeless

Current Staffing:

1 Supervisor M-F 4:30pm or 5:00pm (for 8 hours)

12 FTE Emergency Medical Technicians (EMTs)

7 Part time EMTs

M-F Day shift 7:00am to 7:30 pm -2 EMTs

Sat-Sun 7:00am-7:30am -3 EMTs

M-Sun 7:00pm to 7:30am 5 EMTs

Case Management Services

Location: Most staff are currently based at and take referrals from Sobering Center, 1930 Boren Avenue

There are a few other limited referral points (e.g. Angeline's, Chief Seattle Club)

Staff "follow clients" once engaged.

Hours: 6:00 a.m. to 5:00 p.m. Monday – Friday
(Two case management staff and the nurse have early shifts to engage with clients at sobering center in the morning. REACH staff have a presence on-site until at least Noon. Afternoons, staff are typically out in the field working with clients, and thus in and out of the sobering site.)

Criteria: Homeless when initially engaged;

High utilizer of the Dutch Shisler Sobering Support Center, or other publicly funded services such as the HMC Emergency Department;

Not capable of independent access to needed community resources;

Chronically chemically dependent; and

Does not have a case manager and would not be eligible for Regional Support Network case management.

Number served 2007: 190

Demographics (2007):

Age

Under 45	2%
45-64	67%
25-44	28%
65+	3%

Race

White	48%
AI/AN	32%
Black	16%
Other	4%

Male	76%
Female	24%

Capacity:

Evergreen Treatment Services (ETS) Existing team of 6.0 FTE has capacity to case manage 180 – 190 clients per year (caseload about 30 clients per case manager).

During years 2000 to 2007 new clients accepted onto the caseload has ranged between 21 and 53 per year. **Average number of new clients per year is 36**.

(In 2006, 43 REACH case managed clients were transitioned to housing and case management at 1811)

Seattle Indian Health Board: 1.0 FTE Outreach Worker. Case finding at Chief Seattle Club, Sobering, and other sites (Coordinates with the ETS REACH team).

NOTE: Other resources that are part of the REACH team include a 1.0 FTE Registered Nurse, and a 0.4 FTE mental health professional.